

Introduction

The Maine Department of Health and Human Services (DHHS or the Department) engaged Myers and Stauffer LC to evaluate rates and rate setting methodologies for MaineCare, Maine's Medicaid program. The purpose of this evaluation is to develop recommendations for a comprehensive, streamlined, and coherent system to set rates for specific Medicaid services and programs. This initiative also includes the consultant's development and delivery of a draft plan for the Department's consideration to implement the recommendations. The Department's goal is to establish and maintain MaineCare rates that are sufficient to sustain the financial viability of Maine providers, thereby ensuring that MaineCare members have access to high value services, as required by Section 1902(a)(30)(A) of the Social Security Act.¹

To date, Myers and Stauffer has prepared the following reports:

- Phase 1 Benchmarking Report. This report compares MaineCare rates to rates of selected state Medicaid agencies, Medicare, and commercial payers in Maine. This report may be found at: https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-evaluation
- MaineCare Comprehensive Rate System Evaluation Interim Report. This report provides recommendations for MaineCare's rate setting system as a whole, and for specific service categories as defined by the sections of policy in the MaineCare Benefits Manual. This report also includes details of the analysis and prioritization process used to develop these recommendations. A summary of stakeholder comments regarding the adequacy of the rates and appropriateness of the existing and potential rate methodologies are also included. https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/MaineCare-Comprehensive-Rate-System-Evaluation-Interim-Report-2021.01.20.pdf

In this final report, *Comprehensive Rate System Evaluation Implementation Planning Report (CRSE Implementation Report)*, Myers and Stauffer builds upon work completed to date to provide estimates of the time and level of effort needed to implement the recommendations.

The CRSE Implementation Report expands upon the priority table in the Interim Report that summarizes the policy section-specific recommendations along with the broader recommendations for the system that extend beyond individual policy sections. The CRSE Implementation Report also takes the additional

Although states have flexibility in setting the amounts that they are willing to pay for health care services, Title XIX sets a ceiling and a floor on payments; i.e., the rates have to be low enough to encourage efficiency and economy but high enough to incentivize quality and participation. Section 1902(a)(30)(A) of the Social Security Act states in part "A State plan for medical assistance must... provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Source: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

step of adjusting the priorities from the Interim Report, where appropriate, to reflect the impact of DHHS initiatives that have recently been implemented, are in progress, or that have been proposed as initiatives in the FY22/23 biennial budget. This document provides a starting point for the Department as it reviews these recommendations for potential adoption and assesses the steps needed to implement each recommendation.

Implementation Planning Considerations

This study recommends a dual approach to rate adjustments. First, the study recommends a review of rate methodologies and consideration for rebasing or updating rates. Second, the study recommends application of an inflation factor to rates in periods when no rebasing occurs, or application of a more current Medicare fee schedule. These two steps together, i.e., rebasing and inflation, support MaineCare by promoting adequate rates through a streamlined and coherent system and schedule. This approach replaces the current process for ad hoc changes to rate methodologies and/or rates that may or may not be based on analysis of underlying costs. The resulting system is also more transparent for stakeholders and more predictable from a review schedule and budgetary standpoint. The cadence of these dual components is important to the Department's overall rate setting objectives.

A number of factors affect the manner and timing of the Department's implementation of recommendations arising from the rate evaluation:

- Methodology and rate recommendations may apply across several sections of policy. For
 example, nursing services are present in several sections of policy. To address this challenge,
 Myers and Stauffer recommends analyzing rates and methodologies for services that are
 common across multiple policy sections simultaneously. This creates administrative efficiencies
 in rate and methodology development; however, it also potentially creates a need for more
 extensive data collection, analyses, stakeholder input, and additional time for required
 rulemaking and State Plan or waiver amendment approval from the federal Centers for
 Medicare and Medicaid Services (CMS). Nevertheless, this approach will improve consistency
 and comparability of rates, reduce the chance of rate inequity currently cited by stakeholders,
 and create administrative efficiencies.
- While planning to implement Myers and Stauffer's recommendations regarding potential
 Alternative Payment Models (APMs), the Department should consider MaineCare's existing and
 planned APMs, as well as the broader context for impacted providers, delivery systems, and
 financing infrastructure to coordinate implementation timing and other methodological
 implications.
- DHHS' administrative resources are limited. Implementation activities will place additional demands on staff time, even if DHHS contracts with an external consultant to conduct rate methodology studies. Existing MaineCare staff resources are insufficient to oversee and/or conduct the analyses needed, even with the recommended incremental implementation schedule. MaineCare staff will also have additional responsibilities related to the ongoing monitoring of changes once implemented. These responsibilities may include reviewing utilization of services, expenditures for services, reported access issues, provider concerns, quality reporting, and other implementation metrics. Additionally, MaineCare staff time may be

- needed to consider ongoing adjustments or enhancements to policies based on their monitoring efforts.
- DHHS will also have to consider CMS requirements related to changes in Medicaid rate methodologies during its implementation planning. These considerations are discussed further below.
- The Interim Report recommended the Department consider use of an advisory body to review specific requests for rate changes or to address special circumstances that the recommended schedule may not address, or address in a timely fashion, e.g., CMS requirements, legislation, etc. The recommendations from such an advisory body could alter the timing of implementation activities.

Myers and Stauffer has developed an Implementation Activity Table (Table 1) that identifies major tasks and the associated timing needed to implement recommendations. The Implementation Activity Table is informed by the considerations discussed above.

Implementation Activity Table Elements

The Implementation Activity Table presents sections of policy in Myers and Stauffer's recommended order of DHHS implementation. The order of these recommendations is generally based on the priority table established in the Interim Report. However, the table takes into consideration activities that 1) have already been implemented by DHHS, 2) are in the process of being implemented, or 3) are already proposed for implementation in the near future. Several policy sections have been split in the table to reflect that certain services within the policy may have already been recently addressed while others have not. The prioritization of implementation steps also makes further adjustments as appropriate to fully account for services that cross multiple policy sections and therefore should be addressed at the same time.

The Implementation Activity Table column headings and a description of contents follows.

- Priority Order Identifies the priority order for each section or grouping of sections of MaineCare Policy. It should be noted that the priority order in this table differs from the prioritization in the Interim Report issued in January in order to account for 1) initiatives that the Department has either recently implemented, proposed and/or has in process, and 2) policy sections that should be addressed concurrently to account for similarity of services across sections. These latter "bundles" of policy sections are grouped together and designated by a separate color. Policy sections for changes recently implemented appear later in the table, while policy sections for work that has been proposed or is in process appear first in the activity table. The activity table is generally organized chronologically, with updates that are in process or that should be completed first at the start of the table.
- Policy Section Identifies the policy section number, name, and, for sections where the recommended prioritization order varies by service category within that section, the service category.
- Recommendation Articulates recommended action for the section of policy. Recommendations
 have been refined from the Interim Report.

• Anticipated Directional Fiscal Impact to State - Provides an estimate of the fiscal impact of implementing a recommendation, or if that cannot be determined, provides the anticipated direction of the fiscal impact, i.e., potential investment needed, potential savings, or in some cases, net budget neutrality, where the total expected payments to a group of providers delivering services in that policy section is expected to remain the same (although some codes and some individual providers could see a mix of increases and decreases), assuming utilization remains constant.

This column relates only to the rates paid to providers, and does not reflect administrative costs to the Department, which may include staff time, costs associated with systems changes, costs of purchasing rate databases/ fee schedules, or consulting expenses associated with rate methodology studies.

- Rationale for Priority Order -- States rationale for priority order, including instances where the Department has recently completed, proposed, or begun work on an initiative.
- Estimated Project Start Year and Effective Date These columns present the state fiscal year in which work is expected to begin, and the estimated effective date for implementation of the recommendations. The time from work start to completion is driven by a range of tasks that are common to implementing the recommendations for each section of policy. These include tasks such as:
 - Obtaining required information to establish the methodology and calculate rates. In some cases, this is a fee schedule (Medicare, or in the case of dental services, a commercial fee schedule or database of median rates paid by commercial payers). In others, it is cost data, obtained through cost surveys or cost reports, supplemented with other data as needed.
 - Developing rate models and estimating budget impact of new rates.
 - Meeting with stakeholders to review options when methodology changes are under consideration.
 - Working with CMS to obtain federal authority through approval of a State Plan Amendment (SPA) or waiver. Changes to state Medicaid programs require approval from CMS. In DHHS' experience, receiving approval of a SPA or waiver is typically a 6- to 9-month process from initial drafting, depending on the complexity of the changes.
 - Notifying the public of changes. CMS requires that States provide public notice of proposed changes in statewide "methods and standards" for setting Medicaid payment rates. CMS rules require that the notice be published before the proposed effective date of the change.
 - Adopting state rules. State law requires that rule changes, including modifications to the MaineCare Benefit Manual, go through the formal rulemaking process. This process includes public notice and comment, review by the Office of the Attorney General and, for some rule changes, approval by a legislative committee. Rulemaking takes approximately six months for each affected section of policy, and can take longer depending on the complexity of the changes. Multiple rulemakings can take place concurrently, and the rulemaking time period can often be concurrent with the State

- Plan review by CMS, but it is a separate process involving staff resources within DHHS for each rulemaking.
- Preparing provider bulletins and changes to billing manuals, if necessary, to support implementation of a new methodology and/or rates.

In addition to the administrative tasks listed above, there are other considerations in determining estimated implementation timeframes. These may include:

- The availability of DHHS staffing resources.
- Budget appropriations for rate or inflation adjustments that require investment.
 Legislative sessions usually run January through June (first session) or May (second session). The Department generally determines the fiscal impact estimates for its budget proposals by the end of the prior summer.
- Medicaid Management Information System (MMIS) and/ or other system changes
 necessary to implement recommendations. Implementation of recommendations may
 require programmatic or system changes. An estimate of time needed to conduct a
 required rate study and/or to develop a new methodology is provided; however, time to
 make potential system changes is not included.
- Policies involving complex and/or multiple methodologies and service categories take more time. Complex recommendations also have a longer implementation timeframe, such as the hospital system analysis, because the recommendation covers multiple sections of policy and multiple complex methodologies.
- Additional Notes This column provides information about recent studies, rate methodologies or methodology changes, interaction with other sections of policy or service categories, and other considerations.

Following the Implementation Activity Table, we provide: (1) in Table 2, an overview of when and how rates for different services should be updated for inflation, and (2) in Table 3, definitions of terminology used in this document, Definitions of Terms Used in the Implementation Planning Report.

Table 1 Implementation Activity Table

Priority Order	Policy Section • Service category	Recommendation	Anticipated Directional Fiscal Impact to State	Rationale for Implementation Order	Estimated Project Start Year	Estimated Effective Date	Additional Notes
N/A – already in progress	Section 21: HCBS for Members with IDD or Autism • Residential Habilitation • Day Habilitation	Review and update methodology; rebase rates every 5 years.	Investment required (budget proposal submitted).	Spending initiative associated with rate adjustments proposed by Department in SFY 2022-23 biennial budget. Will 1) complete the process of ensuring rates for Sections 21 and 29 are consistent with the rate study implemented for similar services in Sections 18 and 20 and 2) ensure rates for waiver homes are sufficient to cover updated Maine minimum wage levels.	SFY21	1/1/22	Rate updates enacted in Spring 2020 budget for Section 21, Supported Employment. See rows below for Section 21, Supported Employment, and Home Health, Nursing and Therapies.
N/A – already in progress	Section 29: Support Services for Adults with IDD or Autism • Residential Habilitation • Day Habilitation	Review and update methodology; rebase rates every 5 years.	Investment required (budget proposal submitted).	Spending initiative associated with rate adjustments proposed by Department in SFY 2022-23 biennial budget. Will complete the process of ensuring rates for Sections 21 and 29 are consistent with the rate study implemented for similar services in Sections 18 and 20.	SFY21	1/1/22	Rate updates enacted in Spring 2020 budget for Section 21, Supported Employment. See row below.
N/A – already in progress	Section 91: Health Homes	Continue efforts to integrate with other MaineCare primary care programs under single performance-based Primary Care 2.0 program that will transition away from FFS toward population-based APM. Update Community Care Team rates which are not part of Primary Care 2.0 reform (see row #16).	Net neutral.	Payments in this program are currently not performance-based. The three existing primary care programs are partially duplicative, administratively burdensome, and confusing to members and providers.	SFY20	1/1/22	Primary Care 2.0 would integrate three separate programs (Health Homes, Primary Care Case Management, and Primary Care Provider Incentive Program). MaineCare is currently seeking to leverage multi-payer reform through participation in the Center for Medicare and Medicaid Innovation (CMMI) Primary Care First Initiative. See discussion of Community Care Team rates below.
N/A – already in progress	Section 60: Medical Supplies and DME	Realign rates to conform to the Medicare fee schedule with rate adjustment for urban or rural member location.	Savings. \$774,000 Future updates will be consistent with Medicare.	Savings initiative associated with rate adjustments proposed by Department in SFY 2022-23 biennial budget. Rates vary widely in comparison with rates for Medicare, other states, and commercial plans.	SFY21	1/1/22 Department may need to take a phased in approach; 1/1/22 date reflects completion date for entirety of phased-in approach.	

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
			Impact to State		Start Year		
				MaineCare rates currently exceed CMS Upper Payment Limit (UPL) for codes shared with Medicare. Non-compliance with UPL requires that the State forego Federal match for payments in excess of the UPL with general fund and without federal match. MaineCare is currently evaluating options to change rates to comply with UPL			
N/A – already in progress	Section 97-D: Private Non-Medical Institution Childcare Facilities	Conduct and implement rate study. Staffing levels should be standardized so that rates are more transparent and consistent between providers.	Investment required.	requirements. Spending initiative associated with rate adjustments proposed by Department in SFY 2022-23 biennial budget. DHHS has a rate study currently in progress for Appendix D. There will be new requirements for residential providers under the Families First Prevention Services Act (FFSPA); the rate study will help ensure rates are adequate to allow for fulfillment of these requirements.	SFY21	10/1/21	
1	Section 5: Ambulance Services	Conduct analysis and reassess fee schedule for non-Medicare ambulance services and mileage rates to determine whether adjustments are warranted. For Medicare services, continue updating rates annually based on Medicare fee schedule.	Savings for services that are not on the Medicare fee schedule.	The Department should prioritize services where savings are anticipated, since savings could help pay for recommended increases for other services. Current methodology is consistent with Medicare for Medicare covered codes, non-Medicare codes are high compared to rates from comparison states (on average 240% of comparison).	SFY22	1/1/23	Rates based off Medicare fee schedule are updated annually.
2	Section 13: Targeted Case Management	Analyze whether the service model has remained sufficiently unchanged since the 2017 rate study that was never implemented. If so, update 2017 rate model assumptions and inputs (e.g., the minimum wage increase). If service model has changed substantially, conduct and implement new rate study.	Unknown.	Cost savings may be possible as MaineCare rates are higher compared to rates in comparison states (on average 110% of comparison). However, minimum wage has increased since the last study was completed, so need to assess potential impact of this change on the original recommendation to reduce rates.	SFY22	1/1/23	A rate study completed in 2016-2017 recommended rate decreases; however, the rate change was not implemented after providers expressed opposition to implementation of new rates. MaineCare is conducting quantitative evaluation of Behavioral Health Homes

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
		If this rate study recommends rate decreases,	Impact to State		Start Year		(Section 92) and Community Integration
		consider phase-in of results to mitigate impact.		Whereas Maine pays per 15 minutes, states			(Section 17) and children's TCM in 2021
		Consider using an APM for this service.		most commonly use a per member per month (PMPM) rate to create more			to determine whether DHHS should move toward single model.
		Consider using an Arivi for this service.		sustainability and consistency, paired with			move toward single model.
				quality standards and contract requirements.			If the Department moves to a CCBHC model, providers would likely be
							required to provide the same or similar
							services to Section 17 and Section 13.
3	Section 97-E: Private	Conduct rate study to develop methodology and	Unknown.	Potential cost savings and administrative	SFY22	1/1/23	
	Non-Medical Institution (PNMI-E):	rates based on a standardized service model. Transition from current budget-based payment		efficiencies may be possible for transitioning to a standardized service requirements and			
	Community	to a standardized fee schedule-based		fee schedule.			
	Residences for Persons with Mental	methodology.		Budget-based reimbursement provides no incentive for cost efficiency and is more			
	Illness			likely to lead to inequity across providers.			
4	Section 25: Dental	Update rates using a current benchmark source, such as the median commercial rate from the	Investment required.	There have been no updates to dental rates	SFY22	7/1/22	There could be additional costs to
		Maine All Payer Claims Database (APCD), or	Between \$8.6M total state	in many years and MaineCare rates are very low in comparison to the rates of other			purchase access to a commercial database if MaineCare does not use the
		from a commercial database of charges	and federal	states and to commercial reimbursement			Maine APCD to determine benchmark
		available for purchase.	Benchmarking 67% of commercial median	levels for most dental services, especially endodontics (46%), periodontics (64%),			rates.
			for diagnostic,	removal prosthodontics (61%), fixed			
			preventive, and endodontic services	prosthodontics (53%), and diagnostic services (56%). More than 25% of codes			
			and 50% median for	analyzed for endodontics are low outliers.			
			all other services. and \$28M total state and	Evidence of member access issues due to			
			federal	low rates.			
			Benchmarking 100% of commercial				
			median.				
5 (i – ix):		ated using a Consistent Percent of Medica					
i	Section 90: Physician Services	Update to a revised percent of a more current Medicare Physician Fee Schedule (PFS) and	Investment required.	Rates have not been updated since 2010 and January 2014 for non-facility/non-clinic	SFY22	7/1/22	
		update percentage and Medicare year at least	\$15.7 million (non-ACA	primary care codes. The current fee schedule			
		every three years.	codes) at 71.4% of Medicare PFS	results in variations in the percentage of the Medicare PFS paid (especially for the "all			
		Policy sections based on the Medicare PFS	Wicalcale 113	other services" category of physician			
		should be updated as part of a single effort. This	\$126,000 (ACA codes) at 100% of Medicare PFS.	services) because new services are priced			
		will bring all codes current to the same	100% of ividuicare PFS.				

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	• Service category		Directional Fiscal		Project	Effective Date	
			Impact to State		Start Year		
		benchmark and reduce reimbursement inequity among providers.		using more current Medicare fee schedules than the existing services.			
		The same year's Medicare PFS should be used for all policy sections.		There is also considerable unexplained variation in the percentages of the fee schedule used to set rates for non-MD providers in the sections of policy below.			
				ACA codes are already at 100% of Medicare and reducing these would be disruptive to critical primary care services.			
				71.4% of current Medicare is the level at which no section of policy would experience a net decrease in rates from the standardization.			
ii	Section 14: Advanced Practice Registered Nurse (APRN)/ Certified Registered Nurse Anesthetist (CRNA) Services		Investment required. At 71.4% of Medicare PFS: \$4.2 million (CRNA). \$704,000 (APRN).	MaineCare rates for CRNA average 55 percent of the comparison rates, and APRN average 79 percent. See further discussion related to Section 90, above.			
iii	Section 85: Physical Therapy (PT)		Investment required. 71.4% of Medicare PFS: \$1.8 million	MaineCare rates average 52 percent of the comparison rates. Reported access issues related to low rates, especially for pediatric patients.			
iv	Section 68: Occupational Therapy (OT) Services		Investment required. 71.4% of Medicare PFS: \$4.2 million	MaineCare rates average 55 percent of the comparison rates.			
V	Section 109: Speech/Hearing Therapy		Investment required. 71.4% of Medicare PFS:	MaineCare rates average 95 percent of the comparison rates for agency and 78 percent for independent therapists.			
			\$143,000				

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order		Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
			Impact to State	Reported access issues related to low rates, especially for children.	Start Year		
vi	Section 95: Podiatric Services		Investment required. 71.4% of Medicare PFS: \$782,000	MaineCare rates average 59 percent of the comparison rates.			In 2010, during the legislative emergency session, it was decided that rates must increase for non-hospital providers. Therefore, the legislature bumped up all the service codes. Chiropractic, podiatry, and vision codes were carved out and put on their own fee schedule with no rate increase, and there has been nothing since.
vii	Section 75: Vision Services		Investment required. 71.4% of Medicare PFS: \$2.7 million.	MaineCare rates average 65 percent of the comparison rates.			
viii	Section 15: Chiropractic Services		Investment required. 71.4% of Medicare PFS: \$315,000	MaineCare rates average 73 percent of the comparison rates.			
ix	Section 101: Medical Imaging		Net neutral. Currently 71.4% of Medicare PFS.	MaineCare rates average 76 percent of the comparison rates.			
6 (i – ii):	Policy Sections to In	legrate into the Medicare Physician Fee S	chedule (PFS)				
i	Section 3: Ambulatory Care Clinic Services	Integrate into the Medicare PFS and update percentage and Medicare year at least every three years.	Unknown.	States typically pay for services in this category using the standardized codes and rates in the Medicare PFS. The rate methodology for this Section should be considered at the same time as policy	SFY23	7/1/23	Provider type is not present in other states; best practice is to pay the same amount for same services across settings.

sections that will be based on the updated Medicare PFS. Integrate into the Medicare PFS and update percentage and Medicare year at least every three years. Apply a high-risk population modifier to an already existing physical and behavioral health care assessment code included in the Medicare PFS. Developmental and Behavioral Clinic Services Apply a high-risk population modifier to an already existing physical and behavioral health care assessment code included in the Medicare PFS. Update to a revised percent of a more current Medicare Clinical Diagnostic Laboratory Fee Schedule and update percentage and Medicare year at least every three years. Net neutral. Updating the current fee schedule can address requirements of Section 1903(i)(7) of the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. To the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. To the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. To the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. To the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. To the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. To the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid.	Priority Order	Policy Section ● Service category	Recommendation	Anticipated Directional Fiscal Impact to State	Rationale for Implementation Order	Estimated Project Start Year	Estimated Effective Date	Additional Notes
Developmental and Behavioral Clinic Services Apply a high-risk population modifier to an already existing physical and behavioral health care assessment code included in the Medicare PFS. I Update to a revised percent of a more current Medicare Clinical Diagnostic Laboratory Fee Schedule and update percentage and Medicare year at least every three years. Developmental and Behavioral Clinic three years. Apply a high-risk population modifier to an already existing physical and behavioral health care assessment code included in the Medicare PFS. I Update to a revised percent of a more current Medicare Clinical Diagnostic Laboratory Fee Schedule and update percentage and Medicare year at least every three years. Net neutral. Applying a more current Medicare fee schedule and address requirements of Section 1903(i)(7) of the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. T/1/23 T/1/23 T/1/23					· ·			
Laboratory Services Medicare Clinical Diagnostic Laboratory Fee Schedule and update percentage and Medicare year at least every three years. Medicare Elinical Diagnostic Laboratory Fee Schedule and update percentage and Medicare year at least every three years. Medicare fee schedule "rebalances" rates, increasing rates for some codes and decreasing Applying a more current Medicare fee schedule "rebalances" rates, increasing rates for some codes and decreasing	ii	Developmental and Behavioral Clinic	percentage and Medicare year at least every three years. Apply a high-risk population modifier to an already existing physical and behavioral health care assessment code included in the Medicare	Unknown.	methodology for a service that can be billed using a code and rate from the Medicare PFS is inefficient and adds to administrative			
8 (i – iii): Behavioral Health, Community Support Services, and Rehabilitation and Community Support for Children	7	Laboratory Services	Medicare Clinical Diagnostic Laboratory Fee Schedule and update percentage and Medicare year at least every three years.	Applying a more current Medicare fee schedule "rebalances" rates, increasing rates for some codes and decreasing rates for other codes.	address requirements of Section 1903(i)(7) of the Social Security Act that states that agencies may not pay more for diagnostic laboratory tests than Medicare would have paid. ²	SFY23	7/1/23	

² Section 1903. [42 U.S.C. 1396b] Payment to States. https://www.ssa.gov/OP_Home/ssact/title19/1903.htm.

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
			Impact to State		Start Year		
i	Section 65: Behavioral Health	Integrate outpatient services into the Medicare Physician Fee Schedule (PFS) when possible and update percentage and Medicare year at least every three years. Conduct and implement rate studies for nonstandard procedures, at the same time as other studies serving a similar population to reduce the chance of provider reimbursement inequity or misaligned incentives. Specialty services such as medication management should be evaluated for APMs that support care teams, such as Behavioral Health Homes (Section 92) or the Certified Community Behavioral Health Clinics (CCBHCs) model. Review rates for children's community behavioral health to determine if the rates present barriers to access to services, particularly where there are waitlists.	Unknown.	Developing rates that are comparable for similar services may reduce the potential to create misaligned incentives or inequity in rates. There are benefits to evaluating the services that support children within the community together (i.e., Sections 65 and 28 Community Based Behavioral Health) to ensure coordination and equity across the service system and that rates and incentives meet overall policy goals. Reports of access issues, particularly for children's community- and school-based behavioral health services.	SFY23	8/1/23	
ii	Section 28: Rehabilitation and Community Support for Children	Review rates for children's community behavioral health to determine if the rates present barriers to access to services, particularly where there are waitlists.	Unknown.				
iii	Section 17: Community Support Services	If the service model has remained essentially the same since the 2017 rate study that was never implemented, update 2017 rate model assumptions and inputs (e.g., the minimum wage increase). If service model has changed substantially, conduct and implement new rate study. Review methodology and rebase rates every 5 years.	Unknown.	It is not clear what the original basis is for the current rates for services in this Section. Subsequent rate reviews were not implemented.			Community Integration services duplicate many elements of Behavioral Health Homes (Section 92), without the focus on integrated physical health care. MaineCare is conducting quantitative evaluation of Behavioral Health Homes and Community Integration and children's TCM (Section 13) in 2021 to determine whether DHHS should move toward a single model. If the Department moves to a CCBHC model, providers would likely be required to provide the same or similar services to Section 17 and Section 13.

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	• Service category		Directional Fiscal		Project	Effective Date	
			Impact to State		Start Year		
9	Section 30: Family Planning Agency Services	Crosswalk and change current procedure codes under Section to the Medicare PFS codes with aligned descriptions. Apply a standard percentage discount for non-MD providers. Alternatively, consider option for a bundled clinic rate or other model such as the reimbursement methods in Certified Community Behavioral Health Clinics (CCBHCs) or FQHCS. These methodologies would allow Family Planning clinics to contract to provide a broader array of services.	Unknown.	MaineCare pays 100 percent of the Section 90 rate for most services; there is no record for how other rates were determined. MaineCare rates for Family Planning services average 73.3% of the comparison rate. Range in comparison percentages from 31% to 102% suggests that Medicare PFS adoption, where possible, might rebalance rates and bring more equity to reimbursement across codes. A PMPM bundled rate, tied to performance, would address some additional services that	SFY23	7/1/23	
				Family Planning Agencies provide and the role they serve as a primary care provider. Some states use a clinic rate to support these types of services.			
10	Section 7: Free- Standing Dialysis	Adopt a Maine-specific fee schedule for all services, using Medicare as a starting point, and set to approximate Maine Medicare rates.	Net neutral.	Current rate methodologies represent a mix of approaches without a clear rationale for differences.	SFY23	7/1/23	
		Document payment methodology for all covered services and educate providers on what is included/excluded in the prospective rates.		Most codes have not been updated since 2009-2010			
11	Section 43: Hospice	Consider reducing rates to equal CMS published Medicaid rates, with potential savings. Medicare has separate rates for providers who report quality indicators and those who do not.	Savings. 100% of CMS Medicaid rate:	Some rates exceed the CMS published rates and could be reduced; MaineCare rates on average are higher than comparison rates from other states for some services.	SFY23	7/1/23	
		MaineCare could evaluate using a similar approach.	- \$207,679 total state and federal.	Stakeholders also expressed a desire for MaineCare to mirror Medicare rates.			
12 (i-v): H	lospital Services						
i	Section 45: Hospital Services Acute Inpatient, Non-Critical Access Hospitals, Rehabilitation Inpatient ³	Implement a revised methodology that includes APMs with two-sided accountability and performance payments for quality. Eliminate current supplemental payments and use funds to increase hospital DRG base rates, so that	Unknown.	DRG Grouper version is more than 8 years old and does not reflect changes in technology or service delivery. Current system has many different policies, elements of retrospective and prospective	SFY23	To be determined. 6 months for vendor RFP and selection of consultant.	This recommendation should be implemented at the same time as other Section 45 and Section 46 services.

 $^{^3}$ Section 45: Hospital Services Acute Outpatient, Non-Critical Access Hospitals is included in this section.

Priority Order	Policy Section ● Service category	Recommendation	Anticipated Directional Fiscal Impact to State	Rationale for Implementation Order	Estimated Project Start Year	Estimated Effective Date	Additional Notes
		funding is paid through claims, potentially for CAHs as well as acute care hospitals. Rebase rates to a more recent grouper version and base year and consider use of All Patient Refined Diagnosis Related Group (APR-DRG) grouper to better classify cases. Develop prospective payment approaches for capital. Include all inpatient hospital services in the classification methodology, using a prospective per diem, peer group, or other policy adjustors to pay for certain services. Conduct and implement a rate study to implement standardized rates by service model for distinct psychiatric and SUD units.		reimbursement, and other adjustments that could be simplified. An APM strategy will improve transparency and accountability and support VBP strategies. MaineCare can continue to target special classes of providers with different rate/incentive structures. CMS is increasing scrutiny of supplemental payment programs, which may fuel future policy changes away from this model. ⁴ Current psychiatric unit discharge rates are not consistent across hospitals and there is no known methodology/ rationale for why these rates differ. Rates were last updated for psych units in 2011 and, for SUD units, in 2013.		12 months for stakeholder engagement, system evaluation, and rate development. 9-12 months for rulemaking, submission of State Plan Amendment, and other administrative tasks.	
ii	Section 45: Critical Access Hospitals (CAHs), Inpatient and Outpatient	Consider whether services could be included in a rebased DRG methodology and/or APC approach, through peer grouping alternatives or targeted payment, to provide consistency in methodologies and reduce administrative effort. Consider how CAHs could be included in quality improvement activities, or other APMs that reward performance.	Unknown.	Current approach that requires cost settlement is burdensome for providers and MaineCare. Other payment methodologies may provide incentives for providers to improve care delivery and increase overall value to MaineCare.			This recommendation should be implemented at the same time for Section 45 and Section 46 services.
iii	Section 46: Psychiatric Hospital Services	When rebasing the DRG methodology, consider options for classifying inpatient psychiatric services in a prospective per diem or per discharge payment arrangement, using base year costs for these providers in the same way that the Acute DRG hospital rates are determined.	Unknown.	MaineCare determines inpatient payment through negotiation of charges, which may not have a direct relationship with costs. This practice allows providers to increase charges, and the approach does not provide incentives for efficient, effective, quality care.			This recommendation should be implemented at the same time for Section 45 and Section 46 services.

 $^{^{4}\,\}underline{\text{https://www.manatt.com/insights/newsletters/manatt-on-health-medicaid-edition/congress-delays-medicaid-dsh-cuts-makes-targeted.}$

Priority Order	Policy Section ● Service category	Recommendation	Anticipated Directional Fiscal Impact to State	Rationale for Implementation Order	Estimated Project Start Year	Estimated Effective Date	Additional Notes
		Transition outpatient reimbursement to align with the APC reimbursement methodology that applies to other hospital outpatient services and is benchmarked to a percent of Medicare					
iv	Section 45: Hospital Services Acute Outpatient	Consider reducing rates to outpatient hospitals for certain services delivered in the ASC setting where ASC rates for those services are lower. Decisions about revising payment rates should account for access, quality, and other factors. MaineCare should also consider incenting the use of less costly settings through APMs that reward provider cost efficiency.	Unknown.	Analysis showed that services billed with comparable procedure codes are paid at a higher rate in the outpatient hospital department than in the ambulatory surgical setting, even though MaineCare payment for ASCs is high (119%) in comparison to other payers.			
V	Section 45/46: Inpatient and Outpatient Hospital Based Physicians (HBPs)	Repurpose funding currently used for cost settlement of HBPs to instead be used for performance-based payments in an APM.	Unknown.	A change in methodology could create opportunities for inclusion of additional providers in value-based approaches.			Also see Section 90, Physician Services,
13 (i – iii)	: Nursing Facilities, I	PNMI Appendix C, and Adult Family Care H	lomes				
i	Section 67: Nursing Facility Services	Continue the use of an acuity system, comparable to the practices of other states. Consider approaches to simplify the methodology by implementing prospective rates instead of cost settlement for all components, and incorporating after-the-fact adjustments (e.g. high MaineCare utilization add-on) into the base reimbursement methodology. Evaluate peer grouping methodology and calculation of cost components and ceilings. Implement performance requirements: a quality adjustment pool could be funded with withholds from potential increases, and only those providers with high performance would be paid the quality incentive payment.	Unknown.	A review provides opportunities to continue to use a case-mix methodology, but to evaluate current methodology and respond to/address stakeholder concerns by developing a less complex approach. Numerous state Medicaid agencies use value-based payment approaches in their nursing facility reimbursement methodologies. Approaches range from payment for reporting quality metrics to performance-based payments. In contrast, cost settlement does not incent cost efficiency or value.	SFY23	To be determined. 6 months for vendor RFP and selection of consultant. 12 months for stakeholder engagement, system evaluation, and rate development. 9-12 months for rulemaking, submission of State Plan Amendment, and other administrative tasks.	A new methodology could result in a redistribution of payments across nursing facilities, so Maine Care will have to determine how those adjustments could apply and will likely require legislative changes depending on the exact nature of the methodology. Beginning October 1, 2019, Medicare changed its system from Resource Utilization Groups (RUGs) to the Patient-Driven Payment Model, which predicts a resident's care needs based on their original diagnosis; CMS delayed the phase out of RUGS related questions from the resident assessment, giving states more time to decide if and how they would change their methodologies.
ii	Section 97-C: Private Non-Medical Institution (PNMI-C): Medical and	Conduct review of PNMI C services and rate methodology in concert with nursing facility review to ensure that changes in one setting do not negatively affect the other.	Unknown.	The PNMI-C model is not commonly found in other states, but the methodology most closely resembles what is used for Nursing Facilities.			Considering the age demographics of Maine, there is likely to be an increased need for this service.

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
			Impact to State		Start Year		
	Remedial Service Facilities	Consider options to develop fully prospective rates.		Cost settlement methodology does not incent cost efficiency or value.			
iii	Section 2: Adult Family Care Homes (AFCHs)	Review the service model to ensure it is serving the population's needs as intended. A methodology redesign may be necessary to ensure services are provided in the way the Department intends.	Unknown.	AFCHs are similar to PNMI Cs, in that both are case mix reimbursed and serve similar populations, and both are considered to be alternatives to nursing facilities, so it makes sense to review and update together.			Potential investment for methodology study for residential settings: see Section 97 above.
14	Section 50: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IDD)	Conduct and implement rate study. Consider whether a resident assessment could better distribute payment and reduce need for budget requests and other administrative efforts. Alternatively, review staffing levels and develop models that predict staffing and costs for services so that reviewers can assess budget requests.	Unknown.	MaineCare has not reviewed this methodology in more than 10 years. There are features of the system that may be improved, such as a reliance on provider budget requests to fund additional staffing needs, when there are no staffing model standards by which to assess the requests; there are also no quality incentives included in the methodology.	SFY23 or later.	To be determined. 9 months for stakeholder engagement and analysis of options. 6-9 months for any subsequent rule making or State Plan Amendment changes selected.	Assess potential impact on the waiver programs if methodology and rate changes are made.
15	Section 91: Health Homes (CCT only)	Conduct and implement a rate study for Community Care Teams (CCTs), which will have their own separate section of policy post Primary Care 2.0 reform.	Unknown.	Rates have not been updated since they were set in 2013. Implementation of Primary Care 2.0 may have impact on CCT service delivery model, so should wait to assess rates until post Primary Care 2.0 implementation.	SFY24 or later.	To be determined. 6 months for development and completion of rate study. 6-9 months for SPA and rulemaking.	
16	Section 92: Behavioral Health Homes	Review and update rate assumptions, as necessary. Consider incorporating medication management into this model or evaluate the use of a CCBHC model. Rebase rates at least every 5 years. Reassess performance-based measure and aspect of reimbursement, which currently utilizes a recoupment model.	Unknown.	Rates were last updated in 2016 and are due for review. Behavioral Health Homes may be well situated to serve higher need members if medication management services were incorporated into either this model or a CCBHC approach.	SFY24 or later.	To be determined. 6 months for development and completion of rate study. Additional time would be needed if DHHS chooses to implement a new model, such as	MaineCare is conducting quantitative evaluation of Behavioral Health Homes and Community Integration and children's TCM (Section 13) in 2021 to determine whether DHHS should move toward single model with more substantial accountability for performance outcomes.

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
			Impact to State		Start Year		
				Current performance-based methodology is administratively burdensome and includes minimal risk/reward.		CCBHCs- total of 18-24 months. 6-9 months for SPA and rulemaking.	
17	Section 93: Opioid Health Homes	Review and update methodology Rebase rates at least every 5 years.	Unknown.	Rates last updated in 2019. A new rate study should be scheduled for 2024.	SFY24 or later.	To be determined. 6 months for development and completion of rate study. 6-9 months for SPA and rulemaking.	Pay for performance provisions are being implemented in upcoming 2021 rule changes.
18	Section 97-B: Private Non-Medical Institution-B: Substance Use Disorder Treatment Facilities	Conduct and implement rate study; rebase rates every 5 years. Standardize staffing levels so that rates are more transparent and consistent between providers. Staffing and covered services should be structured to reflect standards established by the American Society of Addiction Medicine (ASAM) levels of care.	Potential Investment.	Last update: 2% increase effective 7/1/18.	SFY24 or later.	To be determined. Once rate study is complete would require funding by legislature followed by 6-9 months for SPA and rulemaking.	DHHS has a rate study currently in progress for Appendix B, funded by the federal SUPPORT for ME award, with an anticipated completion date of spring 2021. The Department does not have a budget proposal to fund any required investment.
19	Section 97-F: Private Non-Medical Institution-F Non- Case Mixed Medical and Remedial Services	Conduct and implement rate study; rebase rates every 5 years. Transition from current cost-settled rates to prospective rates based on standard staffing levels, so that rate methodology is transparent and consistent between providers. PNMI model is distinct from that for other residential settings and should be evaluated to determine if the methodology should be standardized to match similar other service models currently under study such as PNMI-B.	Unknown.	Potential cost savings and administrative efficiencies may be possible for transitioning to a standardized service requirements and fee schedule. Budget-based reimbursement provides no incentive for cost efficiency and is more likely to lead to inequity across providers.	SFY24 or later.	To be determined. 6 months for standardization of staffing requirements, stakeholder engagement, and development of methodology and prospective rates. 6-9 months for SPA and rulemaking.	
20	Section 107: Psychiatric	Rates should be due for rebasing in 2023; should review either sooner or later when there	Unknown.	Rate was determined in late 2018 using estimated direct care costs.	SFY24 or later.	To be determined.	

Priority Order	Policy Section • Service category	Recommendation	Anticipated Directional Fiscal Impact to State	Rationale for Implementation Order	Estimated Project Start Year	Estimated Effective Date	Additional Notes
	Residential Treatment Facility (PRTF)	are active providers and use of this service to provide a better understanding of costs. After this time, rebase rates every 5 years.		There are currently no active providers.		3 months for development and completion of analysis. 6-9 months for SPA and rulemaking.	
21 (i-vi):	HCBS Home Health a	ind Nursing, Clinical, and Personal Care Se	rvices				
i	Section 19: HCBS for Elderly and Adults with Disabilities • Home Health and Nursing	Conduct and implement rate studies; rebase rates every 5 years. Consider equity among nursing rates in different policy sections when reviewing this section.	Unknown.	HCBS Home Health and Nursing services were not included in 2020 and 2021 rate updates.	SFY24 or later.	To be determined. 6-9 months for development and completion of rate study.	See Section 19, Personal Care, below.
ii	Section 20: HCBS for Adults with Other Related Conditions • Home Health and Nursing • Clinical	Examine nursing and PT/OT/Speech services included in these sections to determine if they are unique to HCBS settings and should remain in the HCBS sections, or be included in the nursing/therapy-specific policy sections (e.g., 68 or 85). If services are distinct, then codes should be included in a rate study for HCBS home	Unknown.			Approx 12-18 months for all five SPAs and rulemakings.	See Section 20, Supported Employment, Day & Residential Habilitation, below.
iii	Section 21: HCBS for Members with IDD or Autism • Home Health and Nursing • Clinical	health, nursing and clinical services. If they can be appropriately billed with other standard codes using modifiers, then they should be removed from these sections.	Unknown.				See Section 21, Day & Residential Habilitation, above, and Supported Employment, below.
iv	Section 96: Private Duty Nursing and Personal Care Services • Home Health and Nursing		Unknown.				See Section 96, Personal Care, below.
V	Section 102: Rehabilitative Services	Conduct and implement rate study; rebase rates every 5 years.	Unknown.	The rates for 102 should be brought into alignment with that for comparable services under the HCBS waivers.			

Priority Order	Policy Section • Service category	Recommendation	Anticipated Directional Fiscal Impact to State	Rationale for Implementation Order	Estimated Project Start Year	Estimated Effective Date	Additional Notes
				Section 102, Rehabilitative Services, has not been updated since 2010; however, the comparison percentages for this section are high, ranging from 173 - 199 percent of the comparison rate.			
vi	Section 40: Home Health	Conduct and implement rate study. Examine services included in this section, such as therapies (e.g., OT or PT) to determine if they are unique to the home health setting and should remain in this section of policy or be included in the therapy specific policy section (e.g., 68 or 85). If therapy codes remain in section 40 specific for home health then they should be included in a rate study with other services in this section. If they can be incorporated into the therapy specific sections and billed using modifiers than they should be removed from this section. Dilitation, Day Habilitation, & Supported E	Unknown.	Comparison percentage is close to 100 percent; however, there is a great need to rebalance. MaineCare rates average from 12 to 386 percent of comparison rates.			There is no record of the methodology now in place; there was a rate study completed in 2016-17, but it was not implemented.
i	Section 18: HCBS for Adults with Brain Injury	Review methodology for rebasing in 2025 and rebase rates every 5 years thereafter. Evaluate employment support programs for incorporation of Alternative Payment Model (APM).	Unknown.	Rate study completed and rates updated in Spring of 2020.	SFY24 or later.	To be determined. 6 months for development and completion of rate study. 6-9 months for SPA or waiver updates and rulemaking.	Rate updates enacted in Spring 2020 budget: Sections 18 Home Support (15 min) level I, effective July 1, 2020. Sections 18 Home Support per diem II -IV, effective after rulemaking complete.
ii	Section 20: HCBS for Adults with Other Related Conditions • Residential Habilitation • Day Habilitation • Supported Employment		Unknown.			Additional time may be needed if DHHS chooses to implement a new APM.	Rate updates enacted in Spring 2020 budget: • Home Support (15 min) level I, effective July 1, 2020. • Home Support per diem II -IV, effective after rulemaking complete. See Section 20 Clinical and Home Health and Nursing, above.
iii	Section 21: HCBS for Members with IDD or Autism		Unknown.	The Department has proposed a biennial budget initiative to complete the process, effective July 2021, of standardizing rates for			Rate updates enacted in Spring 2020 budget:

Priority Order	Policy Section • Service category	Recommendation	Anticipated Directional Fiscal	Rationale for Implementation Order	Estimated Project	Estimated Effective Date	Additional Notes
	Supported Employment		Impact to State	Sections 21 and 29 with rates implemented for similar services in Sections 18 and 20.	Start Year		Home Support (15 min) level I, Supported Employment, effective January 1, 2021. See Section 21, Residential and Day Habilitation, and Home Health, Clinical, Nursing and Therapies, above.
iv	Section 29: Support Services for Adults with IDD or Autism • Supported Employment		Unknown.				Rate updates enacted in Spring 2020 budget: • Section 29, Home Support (15 min) level I, Supported Employment, effective January 1, 2021. See Section 29, Residential and Day Habilitation, above.
23 (i-iv) H	HCBS Personal Care S						
i	Section 12: Consumer Directed Attendant Services	Review methodology for rebasing in 2025 and rebase rates every 5 years thereafter.	Unknown.	Rates increased effective April 1, 2020, for personal care services.	SFY24 or later.	To be determined. 6 months for development and completion of rate	
ii	Section 19: HCBS for Elderly and Adults with Disabilities • Personal Care Services		Unknown.			study. 6-9 months for SPA or waiver updates and rulemaking.	See Section 19, Clinical, Home Health and Nursing services above. a
iii	Section 96: Private Duty Nursing and Personal Care Services • Personal Care Services		Unknown.				See Section 96, Home Health, Nursing and Therapies, above.
iv	Section 26: Day	Review methodology and rebase rates every 5	Unknown.	Rates updated for inflation in 2020.			
24	Health Services Section 4: Ambulatory Surgical Center Services (ASC)	No rate adjustments recommended for the time being. MaineCare should consider if APMs might be designed to reward providers for using ASC	N/A	Payment rates are 100 percent of Maine Medicare fee schedule rates; although MaineCare pays a relatively high percentage of the Medicare fee schedule for these services, the costs of services in this setting	SFY24 or later.	To be determined.	

Priority	Policy Section	Recommendation	Anticipated	Rationale for Implementation Order	Estimated	Estimated	Additional Notes
Order	Service category		Directional Fiscal		Project	Effective Date	
		services when possible instead of more costly outpatient settings. Recommendations for potential further action to reduce disparities between ASC and	Impact to State	are lower than costs of similar services provided in outpatient hospital setting. Federal regulations do not permit Medicaid programs to require members to use a	Start Year		
		outpatient rates rely on a review of the Outpatient Prospective Payment System (OPPS) rates for services provided by both ASCs and outpatient hospitals to assess impact of these differential rates on quality, access and other issues.		specific provider, so in order to shift sites of care may need to incent physicians to refer to less costly settings.			
25	Section 9: Indian Health Services (IHS)	No changes recommended.	N/A	Federal Regulations apply.	N/A	N/A	
26	Section 31: Federally Qualified Health Centers (FQHC)	No changes recommended at this time. MaineCare should monitor the amount of services billed outside of the prospective payment system (PPS) to ensure that reimbursement is appropriate.	N/A	Federal Regulations apply. Services offered by FQHCs have grown nationally as they work to integrate physical and behavioral health.	N/A	N/A	MaineCare plans to provide opportunity for FQHCs to participate in Primary Care 2.0 (See Section 91: Health Homes, Priority Order 23 above.)
27	Section 103: Rural Health Clinics (RHC)	No changes recommended.	N/A	Federal Regulations apply.	N/A	N/A	MaineCare plans to provide opportunity for RHCs to participate in Primary Care 2.0 (See Section 91: Health Homes, Priority Order 23 above.)

Table 2 Current and Recommended Inflationary / Fees Schedule Adjustments

	Policy Section	Current Adjustment	Recommended Adjustment				
		Schedule	Schedule				
Rat	Rate study /rebase rates every 5 years, inflation every 2-3 years between rebasing						
1.	Section 2: Adult Family Care Homes (AFCHs)	Annual	Rate study /rebase rates every 5				
2.	Section 12: Consumer Directed Attendant	None	years, inflation every 2-3 years				
	Services		between rebasing				
3.	Section 13: Targeted Case Management	None					
4.	Section 17: Community Support Services	None					
5.	Section 18: HCBS for Adults with Brain Injury	None					
6.	Section 19: HCBS for Elderly and Adults with Disabilities	None					
7.	Section 20: HCBS for Adults with Other Related Conditions	None					
8.	Section 21: HCBS for Members with IDD or Autism	None					
9.	Section 26: Day Health Services	Annual					
10.	Section 28: Rehabilitation and Community Support for Children	None					
11.	Section 29: Support Services for Adults with IDD or Autism	None					
12.	Section 40: Home Health	None					
13.	Section 45: Hospital Services Acute Inpatient, Non-Critical Access Hospitals, Rehabilitation Inpatient	None					
14.	Section 45: Critical Access Hospitals (CAHs), Inpatient	NA/ Cost-settled					
15.	Section 46: Psychiatric Hospital Services, Inpatient	NA/ Cost-settled					
16.	Section 50: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IDD)	Annual / cost settled					
17.	Section 67: Nursing Facility Services	Annual cost settled					
18.	Section 91: Health Homes	None					
19.	Section 92: Behavioral Health Homes	None					
20.	Section 93: Opioid Health Homes	None					
21.	Section 96: Private Duty Nursing and Personal Care Services	None					
22.	Section 97-B: Private Non-Medical Institution (PNMI-B): Substance Abuse Treatment Facilities	None					
23.	Section 97-C: Private Non-Medical Institution (PNMI-C): Medical and Remedial Service Facilities	Annual/ cost settled					
24.	Section 97-D: Private Non-Medical Institution (PNMI-D): Childcare Facilities	None					
25.	Section 97-E: Private Non-Medical Institution (PNMI-E): Community Residences for Persons with Mental Illness	Budget-based/ cost settled					

	Policy Section	Current Adjustment Schedule	Recommended Adjustment Schedule
26.	Section 97-F: Private Non-Medical Institution (PNMI-F): Non-Case Mixed Medical and Remedial Facilities	Budget-based/ cost settled	
27.	Section 102: Rehabilitative Services	None	
28.	Section 107: Psychiatric Residential	None	
	Treatment Facilities		
Up	date Medicare fee schedule and % ever	y 2-3 years	
1.	Section 3: Ambulatory Care Clinic Services	None	Update Medicare fee schedule and
2.	Section 4: Ambulatory Surgical Center	Medicare fee schedule	% every 2-3 years
	Services (ASC)	adjusted annually	
3.	Section 14: Advanced Practice Registered	None	
	Nurse (APRN)/Certified Registered Nurse		
	Anesthetist (CRNA) Services		
4.	Section 15: Chiropractic Services	None	
	Section 23: Developmental and Behavioral	None	7
	Clinic Services		
6.	Section 45: Hospital Services Acute	Medicare fee schedule	
	Outpatient	adjusted annually	
7.	Section 45: Critical Access Hospitals (CAHs), Outpatient	NA / Cost-settled	
8.	Section 45/46: Inpatient and Outpatient Hospital Based Physicians (HBPs)	NA / Cost-settled	
9.	Section 55: Laboratory Services	None	
10.	Section 68: Occupational Therapy (OT) Services	None	_
11.	Section 75: Vision Services	None	
12.	Section 85: Physical Therapy (PT)	None	
	Section 90: Physician Services	None	
	Section 95: Podiatric Services	None	
15.	Section 101: Medical Imaging	None	
	Section 109: Speech/Hearing Therapy	None	
	ner / Mix		
	Section 5: Ambulance Services	 Some: Medicare fee schedule adjusted annually Others: none 	 For Medicare services, update Medicare fee schedule and % every 2-3 years. For non-Medicare services, update for inflation every 2-3 years
2.	Section 7: Free-Standing Dialysis	None	Adopt a Maine-specific fee schedule for all services, using Medicare as a starting point, set to approximate Maine Medicare rates, then adjust for inflation every 2-3 years
3.	Section 9: Indian Health Services (IHS)	Rate set annually by federal government	Rate set annually by federal government
4.	Section 25: Dental	None	Update for inflation every 2-3 years

	Policy Section	Current Adjustment Schedule	Recommended Adjustment Schedule
5.	Section 30: Family Planning Agency Services	None	 If tied to Medicare fee schedule, update every 2-3 years. If bundled rate, Rate study /rebase rates every 5 years, plus inflation every 2-3 years between rebasing
6.	Section 31: Federally Qualified Health Centers (FQHC)	Inflated annually per federal law	Inflate annually per federal law
7.	Section 43: Hospice	Annual	Annual (as required by federal law)
8.	Section 46: Psychiatric Hospital Services, Outpatient	NA / Cost-settled	Update Medicare fee schedule and % every 2-3 years
9.	Section 60: Medical Supplies and DME	 Some: Medicare fee schedule Adjusted annually Others: none 	 For Medicare services, update Medicare fee schedule and % every 2-3 years. For non-Medicare services, update for inflation every 2-3 years
10.	Section 65: Behavioral Health	None	 Move some services to Medicare fee schedule and update every 2-3 years. Other services - Rate study /rebase rates every 5 years, then inflation every 2-3 years between rebasing
11.	Section 103: Rural Health Clinics (RHC)	Inflated annually per federal law	Inflate annually per federal law

Table 3 Definitions of Terms Used in the Implementation Planning Report

Definitions				
Affordable Care Act (ACA)	Comprehensive health care reform law enacted in March 2010 (also known as the Patient Protection and Affordable Care Act) that has three primary goals: • Make affordable health insurance available to more people. • Expand the Medicaid program to cover all adults with income below 138% of the federal poverty level. (Not all states have expanded their Medicaid programs.) • Support innovative medical care delivery methods designed to lower the costs of health care generally			
Physician Services - ACA	The ACA included a mandatory two-year increase in fees to Medicare levels for certain services provided by primary care physicians to Medicare levels to address issues related to access to physician services. Some states, including Maine, continue to pay the ACA rates.			
All Payer Claims Database (APCD)	State databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from multiple private and public payers. Maine's APCD is administered by the Maine Health Data Organization (MHDO).			
Alternative Payment Model (APM)	A payment approach that provides incentives to provide high-quality and cost-efficient care. An APM can apply to a specific clinical condition, a care episode, or a population. APMs vary in design, but all aim to restructure payments in a way that financially incentivize high-value care, taking into account both the quality and cost of care.			
Comparison Rate	Myers and Stauffer selected a sufficient number of MaineCare codes to account for at least two-thirds of spend in each given service category. For each code, an overall "comparison rate" was then generated, equal to the combined average of the five comparison states' rates and the Medicare rate, when available, with each weighted equally. Medicare does not cover all the services for which MaineCare pays and, therefore, is not always included in the comparison rate. Similarly, there may be some states that do not have a rate for a given code. However, this information made it possible to quantify how MaineCare rates across policy areas compare to each other by calculating the MaineCare rate as a percent of the comparison rate.			

Definitions				
Cost Report	A financial report that identifies the cost and charges related to a facility's healthcare activities.			
Fee Schedule	A complete listing of fees used by a payer (Medicaid, Medicare, or commercial insurance) to reimburse a physician and/or other providers on a FFS basis.			
Home and Community-Based Services (HCBS)	Services and support provided by most state Medicaid programs in a member's home or community that provide services to enable the member to stay in a community-based versus institutional setting. Many HCBS services are provided under 1915(c) waiver programs approved for a state Medicaid program by CMS.			
Medicare Ambulatory Payment Classification (APC)	Method of paying facilities for outpatient services for the Medicare program. APCs are an outpatient prospective payment system applicable only to hospitals and have no impact on physician payments under the Medicare Physician Fee Schedule. APC payments are made only to hospitals when the Medicare outpatient is discharged from the emergency department or clinic or is transferred to another hospital (or other facility) which is not affiliated with the initial hospital where the patient received outpatient services. APCs encourage cost containment on a per unit basis but do not contain incentives to reduce volume.			
Medicare Ambulatory Surgical Center (ASC) Methodology	Method for paying for facility services provided in ASCs (e.g., nursing, recovery care, anesthetics, drugs, and other supplies). Encourages cost containment on a per unit basis but does not contain incentives to reduce volume.			
Medicare Physician Fee Schedule (PFS)	Provides rates for more than 10,000 physician services, the associated relative value units, a fee schedule status indicator and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).			
Medicare Hospital Outpatient Prospective Payment System (OPPS)	The Outpatient Prospective Payment System (OPPS) is the system through which Medicare decides how much money a hospital or community mental health center will get for outpatient care to patients with Medicare. The OPPS sets payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices.			
Outlier	Based on a review of the distribution of the comparison percentages across policy sections, we defined outlier rates as those MaineCare rates that are less than 40% of the			

Definitions				
	comparison rate on the low side, and greater than 120% of the comparison rate on the high side.			
Prospective Rates	Rates that are set in advance of services and are known by all parties before services are provided. Encourage cost containment on a per unit basis but do not contain incentives to reduce volume.			
Rate Rebalancing	Rebalancing may occur when rates are adjusted up or down to conform to updated fee schedules or rate setting. Changes may result in some rates going up while others go down and the net total expenditures remain budget neutral.			
Rate Rebasing	The process for studying and analyzing rates on a schedule periodic basis and updating with current data.			
Rate Setting	Establishing the rate methodologies and rates paid to providers for covered services.			
Retrospective cost-based systems	Under this system, the amount paid to a provider of services is determined based on the provider's reported costs after the services are rendered. Providers submit cost reports that are reviewed and receive additional payment if reported costs are more than reimbursement, and make repayments if costs are less than payments. Retrospective cost-based systems contain no incentives for cost containment, and in fact can provide an incentive for providers to spend more.			
Resource Utilization Groups (RUGs)	Resource Utilization Groups, or RUGs, flow from the Minimum Data Set (MDS) and drive Medicare reimbursement to nursing homes under the Prospective Payment System (PPS). A resident is initially assigned to one of the seven major categories of RUGs based on their clinical characteristics and functional abilities.			
State Plan Amendment (SPA)	When a state is planning to make a change to its program policies or operational approach, states send state plan amendments (SPAs) to the Centers for Medicare & Medicaid Services (CMS) for review and approval.			
Supplemental Payments	Lump-sum payments in the Medicaid program that are not directly tied to the provision of particular services. For example, states are statutorily required to make disproportionate share hospital (DSH) supplemental payments to hospitals that serve a high share of Medicaid and low-income patients. In addition, states can also make non-DSH supplemental payments to providers up to the			

Definitions				
	upper payment limit (UPL) of what Medicare would have paid in the aggregate for services provided to a particular class of providers. See the MaineCare Benefits Manual, Section 45 of Chapters II and III for additional information: https://www.maine.gov/sos/cec/rules/10/ch101.htm.			
Waiver Amendment or Renewal	When a state is planning to make a change to services under a 1915(c) waiver they must submit a waiver amendment to CMS. Waivers are also renewed every five years.			